Confidential Questionnaire

Men's Health Study Body

Name______________________________________ Birth Date_________ Today's Date_____________

Address____________________________________ City______________ State_______ Zip_________

Phone Number (home)__________________(cellular)_________________(work)___________________

E-Mail Address____

Referring Physician____

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Yes No

Head & Neck

1. Do you suffer with headaches? ___ ___

   If yes, once a month or less ___ more than once a month ___

2. Do you have known allergies? Food ____ Environmental___ ___ ___
3. Do you have TMJ or does your jaw click? ___ ___
4. Do you currently have a cold? ___ ___
5. Are you being treated for a thyroid disorder? Type________ ___ ___
6. Do you have neck pain? ___ ___
7. Do you have upper back pain? ___ ___
8. Do you have a known history of carotid artery disease? ___ ___
9. Do you have a family history of stroke? ___ ___
10. Do you currently suffer with sinus problems? ___ ___
11. Do you have history of dental problems? ___ ___

    Root canals ____ Dentures ____ Implants ____

    Non-replaced extractions ____ Gum Disease ____

12. Have you had dental cleaning in the past 7 days? ___ ___

13. Have you been diagnosed with elevated cholesterol? ___ ___

Do you have any special concerns or are there any details related to the information above?

Chest, Heart & Lungs

	Yes	No
1. Have you been diagnosed with:		
Heart disease?	___	___
Lung disease?	___	___
Upper spine disorders?	___	___
2. Do you suffer with upper back pain?	___	___
3. Do you suffer with chest pain?	___	___
4. Have you ever had surgery to your:		
Heart?	___	___
Lungs?	___	___
Mid to upper back?	___	___
5. Do you have asthma or shortness of breath?	___	___
6. Do you currently smoke?	___	___
7. Have you smoked in the past 5 years?	___	___

Do you have any special concerns or are there any details related to the information above?

Abdomen & Lower Back

Yes No	Yes No
1. Do you suffer with acid reflux or other digestive problems? Yes___ No___	Have you had surgery or disease in the:
2. Do you suffer pain in the:	Stomach? Yes___ No___
Stomach? Yes___ No___	Spleen(Upper Left) ? Yes___ No___
Below R Breast? Yes___ No___	Liver(Upper Right) ? Yes___ No___
Below L Breast? Yes___ No___	Kidneys ? Yes___ No___

Abdomen? Yes___ No___	Intestines ? Yes___ No___
Lower Back? Yes___ No___	Abdomen ? Yes___ No___
Pelvic Region? Yes___ No___	Lower Back? Yes___ No___
	Pelvic Region? Yes___ No___

Have you consumed alcohol in the past 24 hours? Yes___ No___

Do you have any special concerns or are there any details related to the information above?

Procedure: *You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.*

Patient Disclosure: *I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, but will be an analysis of the images with respect only to the thermographic findings discussed in the report.*

By signing below, I certify that I have read and understand the statement above and consent to the examination.

Patient Signature____Today's Date________